



CITY OF MESQUITE CONTAGIOUS DISEASE EXPOSURE REPORT

I, _____, believe I may have been exposed to one or more of the contagious diseases of Hepatitis A, B, C, Tuberculosis, HIV, or AIDS (please circle all that apply) during the performance of my official duties. The exposure occurred on _____ (date) at approximately _____ (time) at _____ (location).

The circumstances of the exposure were as follows: _____

The source of the exposure was: _____

List other person(s) present at the scene of the exposure: _____

I understand that I am required to undergo a screening test for the contagious disease(s) to which I may have been exposed and that the City of Mesquite will pay for such screening. I further understand that I will be required to undergo a follow-up screening test after the incubation period for the disease(s), but in no circumstances later than 12 months from the date of my exposure.

Employee Signature

Date

ACKNOWLEDGEMENT OF RECEIPT

Department Head Signature

Title

Date

cc: Personnel